MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, April 22, 2004
10:09 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Defining long-term care hospitals
-- Sally Kaplan, Carol Carter

DR. KAPLAN: Good morning. In this presentation I'll briefly review the research findings presented at the March meeting and also present two additional analyses designed to answer questions you raised at the March meeting. Then Carol will present some examples of criteria we've developed that Medicare can use to better define long-term care hospitals and appropriate patients for them. At the end of the presentation we'll ask you to discuss the draft recommendations and the draft chapter.

As we've told you before, growth in the number of long-term care hospitals has been rapid at 12 percent per year from 1993 to 2003. Recently growth has accelerated. During fiscal year 2003 22 long-term care hospitals opened. That same number opened in the first six months of fiscal year 2004. From 1993 to 2001 Medicare spending quintupled from $398 million to $1.9 billion. The number of long-term care hospital cases increased 24 percent from 2001 to 2002. As the number of long-term care hospitals continue to grow they may find it more difficult to fill their beds with appropriate patients.

Long-term care hospitals have very high payment rates. On the screen is a comparison of 2004 per-discharge rates by setting for five diagnoses common in long-term care hospitals. Like any prospective payment system, financial incentives encourage these facilities to admit patients with the least costly needs within a case-mix group.

At the last meeting you questioned why long-term care hospitals are located where they are. Using multivariate analyses we found no relationship between the presence of a long-term care hospital and the share of the sickest patients. We found a negative relationship with certificate of need. In previous research we found a relationship of teaching hospitals to the presence of a long-term care hospital, and the empirical analysis confirmed that. The empirical analysis also confirmed the strong presence of long-term care hospitals in the southern parts of the nation.

Now I'm going to briefly review the findings I presented last month. As you will recall, we had two qualitative components to this research and a quantitative component. For the quantitative work we used episodes of care. In the full dataset we had 4.3 million episodes and we created two subsamples to examine if the results differ for patients who are more likely to be admitted to long-term care hospitals.

To be as conservative as possible in our research this year we did several things to control for severity of illness. First we used every clinical variable available from the administrative data. In addition, we used statistical methods to control for severity of illness, including an instrumental variable approach to control for unmeasured severity.

As you remember, we found that the role long-term care hospitals play is to provide post-acute care to a small number of medically complex patients, less than 1 percent of patients discharged from acute hospitals. These patients are more stable than ICU patients but generally do not have all their underlying problems resolved at admission to the long-term care hospital. A diagnosis of tracheostomy with ventilator support is the single strongest predictor of long-term care hospital use. But patients with tracheostomies represent only 3 percent of long-term care hospital cases. As severity level increases, the probability of long-term care hospital increases.

Supply of long-term care hospitals matters, especially when they are hospitals within hospitals.

We found that acute hospitals and SNFs are the principal alternates to long-term care hospitals. We found that long-term care hospitals users have shorter lengths of stay in the acute hospitals than non-LTCH users. Shorter lengths of stay suggest that acute hospitals and long-term care hospitals are substitutes.

We also found that freestanding SNFs are a principal alternative to long-term care hospitals in areas with and without long-term care hospitals.

On average, long-term care hospitals users are more costly Medicare compared to clinically similar patients who use alternative settings. For patients with the highest probability of using a long-term care hospital we found a positive but statistically insignificant difference in Medicare spending for the episode.

Regardless of the method we used, we found that long-term care hospital users had lower readmission rates than simpler patients treated in alternative settings. This is what we would have expected because long-term care hospitals have to have the capacity to treat hospital-level patients. Our results for death in 120 days are inconclusive.

Last month you expressed concern about whether to reduced probability of readmissions among long-term care hospital users would affect our results on total spending for episodes. We did two analyses to ask you question.

First we examined total episode spending for the 80 percent of patients who aren't readmitted. Second, we roughly estimated the effect of the lower probability of readmissions on total spending among long-term care hospital patients. With both analyses we found that when long-term care hospital admissions are not targeted their patients cost Medicare more. When long-term care hospital care is targeted to the patients most likely to use long-term care hospitals the difference in spending for those patients and patients who use alternative settings are not statistically significant. In other words, a much shorter way to say it is, the story did not change.

The main conclusions from our study are that when admissions to long-term care hospitals are not targeted to the sickest patients, long-term care hospital patients tend to cost Medicare more than patients treated in alternative settings. Based on our analysis, we conclude that long-term care hospital care needs to

be targeted to medically-complex patients that generally cannot be treated in less costly settings.

Now Carol will talk about criteria to better target long-term care hospital care.

MS. CARTER: We had several goals in mind in developing examples of criteria for long-term care hospitals. First and foremost, we wanted to clearly distinguish this level of care from other settings, most notably SNFs. We wanted the criteria to be feasible to administer, both for CMS and for the hospitals. The criteria should establish clear expectations and hold providers accountable for their actions, and reinforce the provision of high-quality care. We wanted the criteria to be consistent with the payment policies of other PPSs. In the longer-term, the criteria should facilitate the adoption of a common patient assessment tool and classification system across post-acute care settings.

During our site visits and numerous interviews we were consistently told about the features of long-term care hospitals that distinguished these facilities from other settings, most notably SNFs and rehab facilities. This is what they told us. They treat sicker patients and that the majority of their patients are likely to improve. They frequently use admission criteria to screen patients.

Many told us about the daily physician involvement that their physicians have with their patients. The level of care that they provided was fairly intensive, ranging from six to 10 hours of licensed nursing care hours per day. They had respiratory therapists available 24 hours a day. They hired physical, occupational, speech and respiratory therapists and had them of staff. And they had multidisciplinary teams preparing and carrying out treatment plans.

Based on these examples we developed example criteria that could be used to ensure that long-term care hospitals treat medically-complex patients. On the next slide you see examples of facility-level criteria.

First, each hospital would establish a patient review process that screens patients prior to admission and periodically throughout their stay and assesses the available options when patients no longer meet continued stay criteria. The purpose is to have each facility have a clear and uniform process that is used to assess each patient.

A standard assessment tool would eventually be used by all long-term care hospitals. This tool needs to provide reliable and valid clinical assessments of patients. Many facilities already use patient assessment tools such as the Apache 3 system. We think all facilities should use the same tool as a way to ensure consistency across facilities in how patients are assessed.

Strong physician presence and active involvement with the planning and provision of patient care was a key feature distinguishing long-term care hospitals from SNFs. One criterion that could establish expectations regarding the types of activities that physicians would be involved in and their availability.

We think consulting specialists should be on call and able to be at a patient's bedside within the hour.

We think the current average length-of-stay requirements should be retained in the near term as yet one more way to ensure that patients require a high level of resources. Over time as the patient criteria clearly delineate the patients appropriately treated in this setting we would reevaluated the need for this criterion.

Multidisciplinary teams would plan and carry out treatment plans. Given the diversity of patients we expect the staff to have a mix of specialized expertise including wound care experts, respiratory therapists capable of rescuing patients, PT, OT, and speech therapists, and staffs capable of providing end-of-life counseling.

Examples of patient criteria are on the next slide. They would ensure patients admitted to long-term care facilities require an intensive level of resources, have good chance of improvement, and cannot generally be treated in other less costly settings. National admission and discharge criteria would be developed for each major category of patients, such as medically complex and respiratory patients. The criteria would specify clinical characteristics such as blood pressure, respiratory insufficiency, or open wounds, depending on the type of patient. And the criteria would delineate the need for specific types of treatment such as IV medications, pulmonary monitoring, ventilator support, and GE suctioning, again depending on the type of patient. Patients who do not meet the admission criteria would be expected to be admitted to a different level of care.

Discharge criteria could be specific to the discharge destination. For example, discharge criteria for a patient headed to a SNF could be different from those headed home.

To distinguish the types of patients treated in this setting from patients treated in other settings a high share of patients, for example, 85 percent, would be classified into broad categories such as complex medical, complex respiratory, cardiovascular, ventilator weaning, and extensive wound care.

To ensure that long-term care hospitals treat the most severely ill one criterion could be that a high percentage of patients need to be assessed at admission at high severity levels. For example, 85 percent of patients would be assessed at the APR-DRG levels three or four. Patients who are less sick can be treated in less costly settings. We appreciate that when the criteria are first implemented it will take time for the industry to adjust to them. Therefore at first this criterion could start at a lower share. Over time we would expect the share required to increase to compensate for changes in coding that are likely to occur.

Admitting patients who require a certain amount of skilled care is another way up to ensure that patients are appropriate to this level of care. For example, a criterion could state that patients required 6.5 hours per day of licensed nurse, respiratory therapist or physical therapist time.

Now Sally would like to walk you though a draft

recommendation.

DR. KAPLAN: On this slide you see the first part of the first draft recommendation. There are actually two slides for this.

It reads, the Congress and the Secretary should collaborate to define long-term care hospitals by facility and patient criteria that ensure that patients admitted to these facilities are medically complex, have a good chance of improvement, and generally cannot be treated in other settings. It goes on, facility-level criteria should characterize this level of care by features such as staffing, patient evaluation and review processes, and mix of patients. Patient-level criteria should identify specific clinical characteristics and treatment modalities.

We estimate that the beneficiary and provider implications are that the adoption of criteria would expand access for patients who actually need long-term care hospital level care. Medicare spending implications are that stringent criteria will result in reduced spending.

The second recommendation is that the Secretary should require the quality improvement organizations to review long-term care hospital admissions for medical necessity and monitor that these facilities are in compliance with defining criteria.

The beneficiary and provider implications are that enforcement of the criteria would expand access to patients appropriate for LTCH level care. Medicare spending would increase for QIOs.

Before you begin discussing the recommendations we want to note that ensuring the appropriate use of long-term care hospitals requires a two-pronged approach. First, criteria such as the ones we've outlined well help ensure that long-term care hospitals already in operation treat patients who require this level of care. But we recognize that in the longer-term refinements to the pre-existing PPSs for acute hospitals and SNFs are needed to make sure that the development of long-term care hospitals is not simply the byproduct of shortcomings in these other payment systems.

On the inpatient PPS side there are three policies that we think warrant further study. First, a classification system that reflects the severity of patients may improve the matching of payments to patient costs and could make acute hospitals financially neutral to treating the complex cases that are currently transferred to long-term care hospitals. This would also likely lower the number of outlier cases that routinely get transferred to long-term care hospitals.

Second, the current outlier policy we believe needs to be studied. The threshold and cost-sharing requirements may contribute to acute hospitals unbundling care to long-term care hospitals, and modifying these policies could make acute hospitals less prone to transfer cases who they could treat themselves.

Third, clear rules regarding hospitals within hospitals will ensure that hospitals do not discharge patients prematurely for financial gain. CMS has expressed their concern about hospitals

within hospitals a number of times and we look forward to seeing what they do.

On the SNF PPS side, we and others have noted the shortcomings in the current RUGs classification system. Refinements that better target patients to medically-complex patients and away from being driven by the provision of therapy services may encourage more SNFs to admit certain types of patients that could be appropriately treated in this lower cost setting.

That ends our presentation.

DR. MILLER: On the implications from provider, beneficiary and on the spending, really I think what we're saying at this point is, we don't know. We're talking about draft criteria. We don't know what would be adopted. There could be some increased access for some sets of patients. There could be some effect on the current spending curve but I don't think we really know. When we get to putting this in the chapter I think this is going to be hard to draft and it's probably going to say in fancy words, we're not real sure. I think that's what we're trying to get across here.

MR. DeBUSK: I think this is an excellent chapter. There's a lot of time, lot of work gone into this. That's quite evident. I want to back up to page 13, examples of facility-level criteria. The standard patient assessment tools, could you expand on that a little bit? What's out there at present?

MS. CARTER: There are a number of different patient assessment tools. The one that we looked at and talked the vendor about was the Apache system. We're not recommending it but it is one out there, but there are many others. Many of the hospitals and sites that Sally visited were using admission criteria screening. InterQual is another one.

MS. DePARLE: I agree that we've really done a lot of work in the last 18 months on this and it's excellent. I just want to raise one thing. In the discussion of the conclusions we said when admissions to LTCHs are not targeted their patients tend to cost Medicare more than patients in alternative settings. We discussed last time the readmissions and you did obviously a lot more work to discover that it still cost more. Remind me what we know? We cannot, I take it, draw any conclusions but the quality or the outcomes being better or worse?

DR. KAPLAN: No, we can't. The only outcome measure that we have is the readmissions. There is no patient assessment instrument in these facilities and that's one thing they would hope to -- we did have a discussion of quality in the chapter, that that's one of the things we would hope to see that would come out of these criteria.

MS. DePARLE: Is that implicit in our recommendation about criteria, that there be a patient assessment? Because it seems to me, down the road we're going to want to be able to look at these various settings. If we got better results I'd be willing to pay more I think.

DR. KAPLAN: The recommendations basically say we need criteria and generally describe what we expect the criteria to accomplish, and then in the chapter we discuss the examples of

criteria we think would be useful in greater detail. The patient assessment instrument and the quality measurement are discussed there.

MS. DePARLE: I guess that leads me to the other question I had. We talked about this a little bit the last time. I'm still not clear on what CMS could do on its own now, understanding that CMS has a lot of other things to do. But if they wanted to do, for example, a patient assessment instrument and asked the LTCHs to use that, as well as other settings, as you point out in the chapter do use patient assessment instruments, could they do that? We use this language about collaborating with Congress. Is that because we're not clear how far CMS can go on its own?

DR. MILLER: I think there's a couple answers. We think that there are lots of things that we're talking about within this criteria that probably can be done administratively. Then what really falls between the Secretary and the Congress I think we are a little bit unclear on. So for the purposes of this discussion we've cast it as both actors being involved in this. There's some murkiness there.

MS. RAPHAEL: I think it's important somehow to put a little broader frame around this chapter which I think has really come a very, very long way. I think what we're saying based on this chapter is that the long-term care hospitals are part of the post-acute care spectrum. They have a role to play for a certain set of patients, and based on a certain set of criteria that we would like to see come into play. So I think it's important to set that there because I think where we're headed is trying to have a more rational post-acute care system, hopefully where patients who will likely have better outcomes in certain settings somehow are more likely to go there.

The other things I was going to ask you, I think Mark answered a question I had which was the impact. If all of this were to come to pass what would it all amount to. I understand that it's hard to capture that. But several other questions that I had based on the letter that we received, one was about the role of rehab in these settings, because rehab expenditures seem to be particularly costly when compared to SNF for these settings. I was wondering if you could comment on the role of rehab. When is it appropriate for rehab patients to go to LTCHs versus rehab facilities? I wasn't entirely clear.

Secondly, could you clarify the issue around staffing? Because a point that's made in the letter is that in SNFs the nursing staffing component encompassed actually unlicensed aide time. I guess I'd like to have that cleared up in terms of what we mean.

Lastly, maybe it's not for today's session but I would like to learn a little more about the QIOs. They don't do any of this now. How well equipped are they to take on this role in the future?

DR. KAPLAN: I'm going to go in reverse order to your questions. QIOs currently have in their scope of work that they review 116 randomly selected cases from long-term care hospitals of month. That just began in January. So they are becoming extremely familiar with long-term care hospitals and the cases.

Some of them already use some of the criteria that we looked at in considering what type admission criteria and discharge criteria you might want to use or might need, and some of the QIOs are already using that criteria for long-term care hospitals.

So I think that they may not be all that familiar with them now but they are becoming much more familiar.

DR. NELSON: Sally, do they make site visits or do they just do a record check?

DR. KAPLAN: That I don't know.

DR. MILLER: I think our impression is that what they're doing is claims analysis and medical records review like they've done in other kinds of settings. I don't think they're going to the facilities and doing conditions of participation type inspections if that's what you're referring to. I'm pretty sure they don't do that kind of stuff.

DR. KAPLAN: I think this is retrospective. It's not they see the patient when the patient is in the facility.

DR. NELSON: That's what I wondered, if it was concurrent or retrospective. Thank you.

DR. KAPLAN: Staffing, aides and SNFs. One of the big points that the long-term care hospitals that we visited on our site visits made was what distinguished them from SNFs were many things, but one of the biggest points was, first of all, daily active intervention of physicians, and staffing. That they provided professional staffing. They did not have a lot of aide care in the long-term care hospital. That is what we are trying to accomplish, to make sure that these are not SNFs and that they aren't souped-up SNFs. So that is why we have put the staffing.

The 6.5 hours actually comes from InterQual criteria. My understanding is this is the level that step downs from ICU units have that level of staffing, which is also what we were told the long-term care hospitals told us, that they're step downs from ICU units.

DR. MILLER: The other part of her question had to do with aides, which we did talk to several people about in the industry. Our criteria says very carefully, licensed. The issue that they brought to us is, can we reach this criteria by using somebody other than nurses? Can we respiratory therapists, wound specialists, that kind of thing. In contemplating this work we see that that wouldn't be an issue. We do not see them reaching this level through aides, however. I thought that was part of your question.

DR. KAPLAN: Now let me go to your last question which was the rehab and the long-term care hospitals. I think one of our concerns is that there are -- the payments in long-term care hospitals for the very same patients that are in rehab are very attractive. I used the major joint replacement as a good example, $67,000 a case in the long-term care hospital versus $17,000. That is for a person with the most ADL impairment and the most comorbidities in the rehab facilities. So that's the most you could get for a major joint replacement in a rehab facility.

Our concern is that long-term care hospitals do not become

very highly paid rehab hospitals. So this is not to say that patients in long-term care hospitals wouldn't receive rehab. This is not to say that a patient who may have been a major joint replacement but had lots of comorbidities and really couldn't be taken care of in a rehab hospital couldn't go to a long-term care hospital. This is really to try and build a line between rehab hospitals and long-term care hospitals.

DR. MILLER: And the line is focused on the severity of the patient.

DR. KAPLAN: Yes, on the severity of the patient.

DR. ROWE: I have two points. This is very nice work; congratulations.

One is, you mentioned on page 14 and one of your recommendations that the average length of stay should be greater than 25 days, and I had two thoughts about that. One is I wonder whether that's average live discharges. These are very, very complex patients. A patient gets admitted, dies after three days, is that counted as a three-day length of stay as we're calculating it?

The second is, would we be better off using the median than the mean? Because there are some patients in these facilities who are there for like two years and then you can have a whole bunch of patients there for five days and you have an average length of stay greater than 25, and that's not really the spirit here.

So I would just ask you to think a little bit about whether that is really the right -- if we're going to have some new recommendations -- I don't know what the distributions are. I haven't seen them. I'm just thinking about that that maybe we could improve that if we looked at some data.

The second point I think is more important and it goes to Carol's comment about the rehab and the business you just said, Sally, about trying to divide rehab hospitals from long-term care hospitals. The first rule is primum non nocare here; above all, do no harm. I think it's great to divide these institutions as long as we're not cutting any babies in half here. I think some of these institutions have evolved along a pathway where they're basically 50 percent rehab hospitals where they're probably getting overpaid for those patients, but they have to keep them in 25 days which is really not what they want do if they're really a rehab hospital, and 50 percent long-term care hospitals. They don't want to be a hospital in a hospital because then they'd have to have different CFOs and medical directors and governances, et cetera.

So going forward I think these are a terrific set of recommendations. Looking backward I would hope that our work reflects the possibility that there are some institutions, and we could have very strict criteria, that perhaps by virtue of the way they have evolved and the role they play we might consider approaching differently.

I'll leave it at that.

DR. REISCHAUER: Of course your first recommendation might be cutting some of these babies in half.

DR. ROWE: I understand. I'd like to see what the data look

like, and if you did both things then maybe would be okay. I understand. If you just did the first thing it might make it worse, not better.

MR. HACKBARTH: We're trying to put together here a conceptual framework defining how this fairly expensive resource is used, and as we do that there may be some unique circumstances that arise out of historical factors that make this less than the perfect fit for particular institutions. I think we ought to acknowledge that explicitly in the text. Having said that, I don't think this is the appropriate forum to try to deal with those circumstances but we ought to acknowledge that they may exist.

DR. NEWHOUSE: In that paragraph I'd like to suggest that we say something about we don't envision that there would be any entry under these criteria. That is to say, or I envision saying something like, the original criterion for defining a long-term hospital was solely that you had an average length-of-stay of more than 25 days. That encompassed a variety of institutions notable for their heterogeneity and that, as Jack said, some circumstances may dictate that we would treat some of these people that qualified initially differently but that we explicitly say something about entry. Because if there's anything we've seen about the long-term hospital industry it's entry. We don't want to set up exceptions that encourage entry into those exceptions.

MR. HACKBARTH: I think that's an excellent addition. Thanks.

MR. SMITH: Thank you very much. This has been good work over the last year. Most of what I wanted to say has been said so I won't repeat it. Looking at recommendation A, we say that these folks generally can't be treated in other settings. A big part of the argument of the chapter is that they are routinely treated in other settings. I think we need to be careful here. Figuring out what the patient criteria are seems to me to be the critical part of both the argument in the chapter and of the recommendations.

We have a suspicion that there are some people who would be better off treated with the more complex apparatus available in the long-term care hospital but really don't say that. Instead we hint at it. On the other hand, our current practice is that they are routinely treated in acute-care hospitals and SNFs and in some cases, rehab facilities. If we really believe the line we used at the end of the first paragraph of recommendation A, that's what we ought to turn our attention and we ought to underscore that in the text of the chapter.

MR. MULLER: My thanks as well for really elaborating our understanding of this. If I can take us back to the slide on page three and the question of the classification of patients. As Carol said, if we have the appropriate care in these hospitals vis-a-vis alternative settings then this is a good place for them in the continuum of care.

But in looking at that table, I must say if indeed the acute hospital is a low cost provider we should gold plate this slide as the first time we've ever shown that. But what are we showing

here in terms of the mix of patients, because that would truly be a pleasant surprise to some of us who always defend the alternative? So what are we seeing here in terms of classification of patients? Because they truly are comparable patients and we know from what you said earlier, the LTCHs are not in all parts of the country and you've shown the predominance of them in four states or so. What are we really measuring here across these patient populations in terms of comparability?

DR. KAPLAN: For instance, the stroke is DRG-14, as an example. That is the per-case payment, a standardized amount that an acute hospital received for each stroke patient. That is the standardized amount that a long-term care hospital receives for each person that has a stroke, that has DRG-14. It's a little bit more complex.

MR. MULLER: So there's obviously differences in acuity --

DR. KAPLAN: Yes.

MR. MULLER: -- because otherwise you would say, everybody should just stay in an acute-care hospital then and not go to these --

DR. KAPLAN: If we could get them to stay in acute-care hospitals that might be our choice, but that hasn't been what we've got -- we haven't been able to make that happen. That's one of our solutions was that we need to look at the acute-care hospital payment system to see if there are ways that we could provide incentives for acute-care hospitals to keep more of these patients.

DR. REISCHAUER: I was wondering whether if you adjusted the acute-care hospital stroke for similar severity level and then look at outlier payments associated with that as well what would the number be? You don't mislead us in any way in your description of this, but that could be the logical comparison really.

DR. KAPLAN: I don't think I can do that for the June report. If you would like that next year maybe, but not this year.

MR. HACKBARTH: Even accepting that you can't do that specific calculation, it might be good to add some additional text that explains that this is not necessarily and apples to apples comparison of similar patients.

DR. ROWE: Why don't you take the acute hospital data out? That's not really what we need anyway. Really it's the long-term care versus the inpatient rehab versus the SNF.

MR. MULLER: In many parts of the country where there aren't the long-term care that in fact is -- so probably in terms of the incidence of cases it's where -- that's where the care is. So I think Bob's point about what's the real underlying payment when you look at the whole payment. But still, outliers aren't that good they can go from six to 31 or from eight to 44.

MR. SMITH: But the first, third and fourth columns up there are subsequent to the second column. In that sense this really isn't apples to apples. It's $6,000 plus $31,000. It's $6,000 plus $34,000. So we should really take that column out of here.

DR. KAPLAN: I think that's a good suggestion, We can also put in the text too that we aren't measuring by severity level on

this.

MR. MULLER: I don't agree with David's conclusion because if they don't go to a long-term care hospital or a rehab hospital then that's it.

MR. SMITH: Right, but the comparison is when they go.

MR. MULLER: No, the comparison is, what does it take to take care of a patient? And if the patient can only be in an acute hospital because there's no alternative, that's what it takes. So the patient is the comparative point, not -- then you look at the patient across different settings.

MR. SMITH: That's right. But then it would be additive in many and in some cases, most cases, right? The episode of care is not always longer than the acute stay, but often is.

MR. MULLER: Yes, but then oftentimes it's in hospice or some other kind of nursing home. Not in a rehab. Probably then the nursing home is more likely. Probably in terms of the incidence of care around the country I would guess the most common is the acute hospital followed by the nursing home in terms of where the bulk of the cases are. Then in settings where there are rehab hospitals and long-term care you have this payment pattern that's described here. But if you just look at flat out incidents, my guess is, the way you said it, it's column two and four, not a combination of -- just in certain cases about the country.

MS. BURKE: At the risk of being positioned as being opposed to long-term care hospitals I will make the following comment. Let me first ask a question. In the context of the growth of long-term care hospitals note is made in the chapter about the particular increase in the in-house or the hospital related long-term care hospital activities. I wondered what we knew about the proximity of that growth, those particular institutions, to other freestanding? And to what extent we can infer that there's a certain amount of defensive action that has taken place; i.e., are we seeing the growth in the in-house hospital-based long-term care units in close proximity to freestanding long-term care?

Is this a market-driven kind of issue? Are they essentially trying to compete for patients? Are you seeing, for example, inpatient facilities developing in areas where there are no long-term care freestandings, or do they tend to be in the same markets? That would be my first question. What do we know about that? So to what extent is this a defensive mechanism?

Secondly, I have a question as to whether there is any inherent difference between those two types of facilities. You note that on average those that are located within hospitals tend to be smaller, that their referral patterns tend to be slightly different, neither of which is terribly surprising. Are there any other aspects of those facilities, either the patients they see, the costs that are reported, the nature of the services, the lengths of stay, the mix of specialists or staffing patterns that are different between those two kinds of facilities? I would be interested in that as well.

Going back to David's point, and he said it far better than I did, and I think also touching on Carol's. I am fundamentally concerned about a statement which suggests that these are

patients that because of the nature of the acuity of their condition requires what is now provided in these facilities when in fact the majority of these patients are being seen in other kinds of facilities around the country. So I think you're very wise to have suggested that part of what must happen is to re-look at the payment system for other facilities that are in fact taking care of the majority of the patients that present themselves in exactly these situation, because it presumes that people that don't have these in their neighborhoods are somehow disadvantaged. So I think your point to make that part of our recommendation ought to be highlighted, that the bulk of these patients really are being cared for arguably in other settings. And let us not assume that the only answer is to develop one of these in your neighborhood. But rather let's find something to do about the payment system that effectively deals with the patient irrespective of where the patient is located. Unless there's something fundamental that we ultimately want to say about other facilities never fundamentally being able to take care of these patients, that a hospital will never be able to take care of a step-down sub-acute patient, which I find somewhat hard to believe. That somehow someone who's been discharged from a unit can't be taken care of in a hospital. It concerns me about hospitals.

So I think that point ought to be, perhaps, emphasized even more strongly, that we really need to look at where patients are being treated, make sure that the payment system reflects the needs of the particular patient. But I would also in future work like to understand the nature of this sort of what has occurred in the growth of these particular facilities in hospitals and what is that suggesting to us about those particular hospitals and the way they're structured and what they're responding to?

MR. HACKBARTH: Could I address the last point? I think the point that Dave made about the language in draft recommendation, that generally cannot be treated in other settings, is exactly right, and I think it is at odds with an important made in the chapter.

Moreover, I strongly agree, Sheila, that the recommendations related to the acute hospital, severity and outliers and also looking at the SNF payment system, I think they are critical parts of this chapter. So when we get to the draft recommendation what I was going to propose is to delete that last phrase about generally cannot be treated in other settings.

DR. KAPLAN: Let me just briefly try and answer your question about hospitals-within-hospitals. A lot of what you're asking I can't answer. I can't tell you but difference in staffing or difference in cost structure because we don't have PPS costs. I think to look at it in the pre-PPS world is fishy at this point.

We did make an attempt to see if we could find differences using our multivariate models and the instrumental variable approach, to find the differences between the hospital-within-hospital patients or episodes and the freestanding episodes, and we really were not able to get stable parameters. So we have to

conclude at this time that there isn't a difference. I want to make that real tentative because it's really because we couldn't get the stable parameters.

Now if we do re-do this work post-PPS we might find a difference.

MS. BURKE: Should I assume, because it doesn't suggest otherwise, that the growth in these particular, the hospital-based, are following the same geographic pattern, or are they more distributed?

DR. KAPLAN: I think they're more distributed. First of all, almost all of the latest growth is hospital-within-hospital. They now represent 50 percent of the long-term care hospitals. CMS makes the point that every long-term care hospital that has opened up since the PPS went into effect is a hospital-within-hospital.

There is some that have opened up in markets where long-term care hospitals already existed. For instance, the 35, 36 long-term care hospitals that are down in Louisiana, there are a couple freestanding ones down there. But most of those are hospitals-within-hospitals. I would say that the new trend is almost all to hospital-within-hospital. So anything that's opening up since 2001 --

MS. BURKE: But is it largely staying in the same general geographic area?

DR. KAPLAN: No, they're spreading out more.

MS. BURKE: So they're going north, they're going west, they're going central.

DR. KAPLAN: Right. I'll give you an example. For instance, in St. Louis there was a long-term care hospital, a Kindred long-term care hospital, the old Vencor chain that's been here since, I want to say the early '90s. Now in the last few months there's been a hospital-within-hospital that's opening, one or more in St. Louis. So it's kind of hard to tell what I think you're trying to get, is it market or is it because competition that the hospitals are opening them up?

MS. BURKE: Right, or whether -- part of this is my trying to understand how much of this is really driven by the need for these services and by patient needs that aren't being met by other capacity, and whether or not we are seeing in fact the spread across the country or whether they are staying largely in certain areas where there's been a history and where the market might suggest that there's an opportunity to compete for patients where there's already been a pre-established presumption that these are a better alternative. I'm just trying to understand how widespread this has become as we look at this going forward.

DR. REISCHAUER: Can I just add a footnote on to that? Early in the chapter you mentioned that 80 percent of the revenue of long-term care hospitals comes from Medicare. We know there are some older ones and some different types of ones. If we just looked at the new ones and the hospitals-within-hospitals is this like 95 percent Medicare, so one would presumptively come to the conclusion that it is an artifact of the Medicare payment system that has created the growth that we're seeing?

DR. KAPLAN: I can only answer based on our site visits,

because we don't have cost report -- the share of how much Medicare pays comes from the cost reports. We don't have cost report since the PPS. Some of the anecdotes we heard when we were out at site visits was that more than 80 percent is coming from Medicare in some of these facilities.

DR. WAKEFIELD: Just a couple of questions. On the data that you have that show the long-term care hospitals users have fewer admissions, will you remind me what the categories of comparison were there? Lower than just SNF or lower than readmitted back into the hospital, rehab facilities, et cetera. So which category was that comparison to?

Also related to that, would it be inappropriate to suggest that after these criteria were put in place and we started to say, because we're basically incenting that patients be taken care of in different settings -- would it be inappropriate to suggest that there be some tracking of any changes in readmission rates after the accommodation of these criteria? Would there be some reason why we wouldn't want to do that, to make that kind of a suggestion? I'm not suggesting it as part of a recommendation but would that be a piece of information to be looking at after the implementation, because we're suggesting that there's some subset of patients that are best treated in non-long-term care facilities, or treated at least equally well. Would that be worth continuing to take a look at?

Then unrelated to those two points, the criterion that speaks staffing and the use of just licensed personnel, that application of that criterion, it sounds like you were suggesting that basically all long-term care hospitals already staff maybe with just licensed personnel or at least we're suggesting that they all should, rather than using aides. Am I misunderstanding that?

DR. KAPLAN: We're not suggesting that they not staff with aides. What we're saying is for the staffing level that we're talking about that aides would not count towards that. Only licensed people would count towards that.

DR. WAKEFIELD: Part of the reason why I was asking that was because acute-care hospital staff by and large, or many of them that I'm familiar with, staff with nurse aides as part of that mix of staffing. But I take your point, it's the counting of that level of staffing.

Then will you come back to my first point for me?

DR. KAPLAN: Yes, I was going to answer your first question. You were asking me whether the readmission analysis, who the comparison was. If you think of it, what we're comparing is people of equal severity level. And we're comparing those that use long-term care hospitals versus those that don't. So we aren't comparing against any particular setting. We are comparing those who used other settings.

DR. MILLER: Who use post-acute care.

DR. KAPLAN: Yes, it would be. It's an apple to apple comparison.

DR. WAKEFIELD: So based on the work you've done would you find value in continuing to take a look at those readmission rates between those that use long-term care hospitals and all

others over time after these criteria were applied and the patients start to shift out differently in terms of where they're actually getting services? Would that help tell us something about what might have been triggered or not by the application of these criteria?

DR. KAPLAN: I don't think it would hurt to track it. I guess the point that I come to on the readmissions is it's one of the few things that we have -- I actually think it's a fairly weak outcome measure -- for facilities that have to be licensed as a hospital. They should be able to handle almost everything, so we would expect those readmissions. But I think readmissions are always an important issue to track in every setting, because Karen and the other quality people presented readmissions for avoidable conditions are a huge quality indicator.

So yes, I think we should. But at the same time I don't think we want to bank on that one. I think we need a lot more than that.

MR. HACKBARTH: Two more comments then we need to turn to the vote.

DR. NEWHOUSE: I'd like to follow on where Sheila and Bob were and go maybe a few steps further and actually propose another recommendation, which is that we suggest a moratorium on new hospitals-within-hospitals. I see the hospital-within-hospital fundamentally is a threat to the integrity of the prospective payment system, if you can shift your long-stay patients off to another floor of the hospital and get separately reimbursed.

As a second order and speculative point at this point, but it may well be that those patients are actually different than the patients in the freestanding long-term hospitals, and we get into a kind of freestanding -- like we have freestanding versus hospital-based SNFs and these are really two different groups of patients and this system doesn't fit the other one any way, although I'd lay emphasis on the first point, that if we have a per-case system for the acute hospital it seems to fundamentally threaten that to set up a hospital-within-a-hospital where you can shift your long-stay patients.

MR. SMITH: Very quickly. Ralph is surely right that my suggestion of eliminating column two on page three of that chart doesn't solve the apples to giraffes problem, but leaving it there doesn't either. I wondered whether or not we can get some episode data where it's acute-care facility plus post-acute, or in those cases where it is simply a stay in an acute hospital? So that we really are looking at the episode here rather than the current misleading use of the acute-care number in cases where there's a discharge to a post-acute setting.

Second, Glenn, I think you're right about changing recommendation A, but I think part of what you said in doing that suggests yet another new recommendation . Building on Sheila's observation, we're not going to fix this simply on the long-term care hospitals side. We've got to address both the SNF and acute-care PPS in order to get them working together. I think that's where Joe was headed, get them working together rather than being payment-driven substitutes for each other.

Some maybe we can translate the observation that Sally and Carol make at the end of the recommendations into a third recommendation which urges the reforms that they outlined in both the acute and SNF PPS as part of getting this one right.

DR. KAPLAN: The only thing I want to say is we've made the recommendation on SNFs three years in a row now. I just want to point that out, that it has been three years.

MR. SMITH: Just take advantage of the opportunity to underscore our previous recommendation.

DR. KAPLAN: But I think we need more study of the acute-care hospital before we can really -- I personally feel strongly that we do need -- we might fix things for long-term care hospitals, but we might be messing things up for other sectors. I think it's a bigger issue than just for the 100,000 discharges in long-term care hospitals. That's my concern, is that we -- I think it is important and I think it's work that we should do, but I just don't know that we should make a recommendation that CMS run off and fix something that we haven't studied, especially if you consider the competing demands on their time now with MMA. I think we want to give them a little better direction than -- fix it how?

MR. HACKBARTH: Help me out. The something in that sentence, fix something, was what?

DR. KAPLAN: Fix the acute hospital PPS. We've already told them we want them to fix the SNF PPS.

MR. HACKBARTH: What I thought we were saying is that -- we can reiterate the specific recommendation on SNFs, and what I thought we were saying with regard to the acute hospital is that we think these are areas that require further study, as opposed to I don't think we've got the foundation for saying we're recommending a severity adjustment for inpatient PPS. We may well do that in the future, but we don't have the foundation for that established right now.

DR. KAPLAN: I'm sorry, I misunderstood what David was saying. So you want to reiterate the SNF PPS --

MR. SMITH: We ought to do the SNF recommendation and we ought to underscore the need to lay the groundwork to --

MR. HACKBARTH: Exactly.

DR. ROWE: I don't want to prolong this. We've gone a long time and I know you want to end this, but Joe just suggested an additional recommendation about a moratorium. I think if we we're going to do that we're going to have to suggest until when? Usually moratoria have -- until what happens? When is the end of a moratorium? What are we trying to do, just call time-out? Is it some kind of study or is it some kind of clarification, or are we calling for a cessation?

MR. HACKBARTH: Here's my view of it. Over the course of the last two meetings at least Joe and Bob and Sheila and maybe some others as well have expressed concern about the hospital-within-hospital phenomenon. Personally I find the way they presented it pretty compelling. I'm convinced that it's something to watch and look at.

Personally though, I feel it's a bit premature to go to the step of recommending a moratorium. I would like to see more

evidence, more data of the sort that Sheila was asking for, comparing the hospital-within-hospital to the freestanding, so that we have a foundation, an analytic foundation for saying this looks more, pardon the expression, like a PPS-unbundling tool than an institution that is like the freestanding. I don't think we have that factual foundation established yet.

Now I know the counter-argument would be, don't let them proliferate rapidly while you're getting the data.

DR. REISCHAUER: You're increasing the sample size.

[Laughter.]

MR. HACKBARTH: Personally I would prefer to do the analysis first. A moratorium in the context of the Medicare program is a pretty significant step and I don't like to take steps without more analysis. My take on it. Welcome any reactions to that.

MS. BURKE: I wouldn't disagree with you, nor would I necessarily disagree with Joe. I think it is a question of timing and making sure that we are fully informed. I agree with you that we ought not today contained make that decision without being fully informed. I think there are a series of questions around the nature of the patient they are serving, what it says more fundamentally about the hospital and about the structure of the payment system. It raises issues about transfers. There are a whole series -- all these issues are wrapped up with one another.

I think I would support your suggestion that we give more thought and analysis to the nature of these patients and the potential impact. I don't want to either disadvantage the hospital, nor do I want to create an incentive for more fracturing. So I would support your desire to get more information and make a decision, but for what it's worth, simply say that there is concern. That we are trying to understand it, and let folks know that what we don't want to see is this unbundling. And we're going to be looking very closely at exactly who these patients are, what it is that's being done, what is the problem they're trying to solve and is the right way to solve it.

DR. NEWHOUSE: I don't see how it could fail to be anything but unbundling, because they've been an acute-care hospital. If it hadn't been for the LTCH they would have used some other --

MS. BURKE: Of course that's the question which I'm trying to understand, which is what is the problem that they are trying to solve? Is it a function of the payment system that does not adequately acknowledge that there are patients of an acuity level and require resources that we don't currently acknowledge or support? I don't know. LTCHs developed for some reason. They developed in three towns or whatever, and what we now see is this proliferation.

I don't want it simply to be taking advantage of a payment system but I want to understand -- the argument that many people that have gone and spent time there suggest that these are really qualitatively different patients that require qualitatively different services. I want to understand how that reality exists, knowing that most of these patients are not treated in LTCHs but in fact are treated in our current hospital structure

or nursing home structure. What is it that we need to do going forward that fundamentally takes care of the patient? What is it that we need to do?

DR. NEWHOUSE: Which, of course, could be true.

MS. BURKE: Absolutely. I'm not assuming that it isn't. But fundamentally what it ought to be is a payment system that takes care of the patient, irrespective of where the patient resides. My concern is I'm not sure I fully understand the difference and whether or not what we've allowed to have happen is in fact to the advantage of the patient. Maybe it is, in which case we ought to do it differently.

MR. HACKBARTH: I think you're making important points and they apply both to the freestanding and the hospital-within-hospital, and the gist of what we're doing here is saying that we believe that there ought to be patient and facility criteria to help assure that this expensive mode of care is applied only to a much smaller subset of patients. That would apply in both instances as well.

DR. NEWHOUSE: I was going to respond to Jack but I think it's also a response you, because it's clear that the Commission doesn't want to go to a formal recommendation here, but that we should in any event initiate a study here of who is using the hospital-within-the-hospital and whether in fact this reimbursement system fits that group, as opposed to all users of LTCHs.

MR. HACKBARTH: Okay, we are well behind schedule so let us turn to the vote. So we have --

DR. REISCHAUER: Can I just ask a point of clarification on recommendation A? You used an interesting term, which is Congress and the Secretary should collaborate. Is this something that does not require legislative change?

DR. KAPLAN: I don't think we're clear as to exactly what CMS can do without legislative change and what it can't.

DR. MILLER: Some of it may. Most of it is probably is administrative, but some of it may and that's what we're trying to do.

MR. HACKBARTH: We still may want to just delete the collaborate and just say, the Congress and Secretary should define --

DR. KAPLAN: That would be great. We can do that. We've taken the last phrase -- unfortunately I'm not able to revise it right here, but we've taken the last phrase off of here and put an and between medically complex, so that the recommendation would read --

MR. DURENBERGER: Can I ask about that? I'm reading this first part as a preamble and the other part as the important part, the criteria and so forth. I'm looking at recommendation A with this third line in it which is, and generally cannot be treated in other settings.

MS. RAPHAEL: We took that out.

MR. DURENBERGER: Not yet.

MR. HACKBARTH: That's the proposal, to take that out.

MR. DURENBERGER: My question is whether we should take it out or if there's an alternate.

If it stays as cannot be treated in other settings then it draws a very bright line. But as a preamble to getting into the criteria and some of the other problems, it seems to me that if the reality is -- and I'm reflecting on my own community where we've had one for 15 years, it's non-profit, it's part of a large health system and everybody refers to it -- are not likely to be -- these are people who are not likely to be treated in other settings who are going into an LTCH.

MR. HACKBARTH: The problem is that in large swaths of the U.S., including my part of the country, these institutions don't exist, either variety, freestanding or hospital-within-hospital. So it literally is not true to say that they cannot or should not or primarily not, and that's one of the basic findings of our work.

MR. DURENBERGER: I understand that, but I'm back at Sheila's very last point which is the patient. I'm not saying that in your part of the country patients are always getting, these very complex patients are always getting all of the care that they need in one of your regular acute-care hospitals. I'm reflecting only on my own experience which says, a lot of hospitals in my community would prefer to have a long-term care acute hospital, staffed as they are, for certain very complex cases, so they've created one in our community.

So I'm trying to express a concern for the patient and the implication that in many places where the long-term acute-care hospital it is because other hospitals and other people in that community have decided it would be better for patients to have this kind of a specialty mix service. I simply want to make that point. Maybe we can't make it without -- I don't have the language to alter that either.

MR. SMITH: Dave, isn't the recommendation as modified perfectly consistent with what you just said? Which is really the first point.

MR. DURENBERGER: And I might not even be making if we weren't taking it out.

DR. KAPLAN: Are you comfortable with getting rid of the collaborate to and have it read, the Congress and the Secretary should define long-term care hospitals by facility and patient criteria that ensure that patients admitted to these facilities are medically complex and have a good chance of improvement. Then go on to, facility-level criteria should characterize this level of care by features such as staffing, patient evaluation and review processes, and mix of patients. Patient-level criteria should identify specific clinical characteristics and treatment modalities.

MR. MULLER: On complex, complex can mean many things, so not too much wordsmithing. Are we meaning more complex or do we -- is that the implication here, based on what we're finding, especially going back to this comparison of, at least the way I read table three was these are far more complex patients, otherwise they wouldn't have payment rates at the outlier point, five, six times of the acute rate. So are we saying these have to be more complex than what would be seen in the acute settings or just complex?

MR. HACKBARTH: It is a complication. I prefer to leave it the way it is here. If you add the word more then the reader anticipates that we're going to describe the relative, relative to what, in the ensuing paragraph, and we don't have the basis for doing that. So I understand your point but I think it would complicate matters to add more.

So draft recommendation A, all opposed?

All in favor?

Abstentions?

Okay, draft recommendation B. I think we can forgo the re-reading of it. All opposed?

All in favor?

Abstentions?

Okay, we are done.